United States Department of Labor
Employees' Compensation Appeals Board

S.R., Appellant	)	
and	)	**Docket No. 18-1295**
	)	**Issued: March 20, 2019**
DEPARTMENT OF JUSTICE, FEDERAL BUREAU OF INVESTIGATION, Birmingham, AL, Employer	)	

Appearances:
Stephen V. Barszcz, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
VALERIE D. EVANS-HARRELL, Alternate Judge

JURISDICTION

On June 19, 2018 appellant, through counsel, filed a timely appeal from a May 2, 2018 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.[3]

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

[3] The Board notes that appellant submitted evidence on appeal. However, the Board's *Rules of Procedure* provides: "The Board's review of a case is limited to the evidence in the case record that was before OWCP at the time of its final decision. Evidence not before OWCP will not be considered by the Board for the first time on appeal." 20 C.F.R. § 501.2(c)(1). Thus, the Board is precluded from reviewing this additional evidence for the first time on appeal. *Id.*

ISSUE

The issue is whether appellant has met her burden of proof to establish that her diagnosed medical conditions were causally related to the accepted May 2, 2016 employment incident.

FACTUAL HISTORY

On May 5, 2016 appellant, then a 39-year-old investigative specialist, filed a traumatic injury claim (Form CA-1) alleging that she sustained neck injuries, a headache, and seatbelt burn on May 2, 2016 when the vehicle she was driving was rear-ended while in the performance of duty. She stopped work that day.

By development letter dated May 9, 2016, OWCP advised appellant of the medical and factual evidence needed to establish her claim, including a detailed description of the May 2, 2016 employment incident, and a narrative report from her physician explaining how the event caused or aggravated a medical condition. It also asked the employing establishment to indicate whether she was in the performance of duty when the incident occurred. OWCP afforded 30 days for responses.

On May 18, 2016 S.H., a senior investigative specialist at the employing establishment, responded that appellant was in the performance of duty at the time of the May 2, 2016 vehicular accident.

In a May 31, 2016 statement, appellant described the May 2, 2016 motor vehicle accident and maintained that she was in the performance of duty when it occurred. An attached Alabama Uniform Crash Report described the May 2, 2016 accident and indicated that appellant's vehicle was hit in the right rear.

A May 2, 2016 emergency department report indicated that appellant was seen by Dr. Amy Stucky, Board-certified in family medicine, and Dr. Patrick O'Hare, Board-certified in emergency medicine. Appellant's diagnoses were listed as "strain neck level muscle, fascia [and] tendon"; "strain thorax back wall muscle [and] tendon"; and "strain lower back muscle, fascia [and] tendon." X-rays of her right shoulder, thoracic spine, and lumbar spine taken on May 2, 2016 revealed no significant abnormality.

In a May 9, 2016 report, Dr. Ryan C. Aaron, a Board-certified physiatrist, noted that he had seen appellant in the past for left-sided neck pain. He reported a history that her pain worsened one week prior following a motor vehicle accident, and that it now also involved the right side of her neck and mid-thoracic area, and that she had a static sensation in her ears, and resolving tingling in her last two fingers bilaterally. Dr. Aaron noted tenderness to palpation in the upper and mid-thoracic paraspinals. He referred appellant for consultation with a neurosurgeon.

Dr. John D. Johnson, a Board-certified neurosurgeon, saw appellant on May 26, 2016 for a complaint of neck pain of chronic duration. He described a history of a 2011 injury with multiple exacerbating episodes and incidents. Dr. Johnson noted that appellant took a variety of medications, but that her pain was quite severe and she was unable to work. Physical examination demonstrated mild decreased sensation in the ulnar nerve distribution on the right, a positive Spurling's which produced neck pain only, and pain to palpation of the posterior cervical spine and with neck extension. Dr. Johnson noted that cervical spine x-rays that day demonstrated a

mild loss of cervical lordosis and loss of disc space height at C4-5 and C5-6. He noted his review of a March 3, 2016 magnetic resonance imaging (MRI) scan of the cervical spine which showed very mild disc bulging at C3-4, C4-5, and C5-6, but no high-grade cervical spinal stenosis or severe neuroforaminal narrowing, and that a May 2, 2016 computerized tomography (CT) scan of the head and cervical spine showed no significant abnormality.[4] Dr. Johnson diagnosed chronic axial neck pain and mild degenerative disc disease. He commented that, although appellant had musculoskeletal complaints, he did not find evidence of myelopathy or radiculopathy.

The record includes medical evidence that predates the May 2, 2016 motor vehicle accident. On March 7, 2016 Dr. Aaron reviewed a cervical spine MRI scan, noting that it demonstrated mild degenerative changes from C3 to C6. On April 22, 2016 he noted appellant's complaint that any activity aggravated her left-sided neck pain and that it was affecting her quality of life, including her work.

By decision dated June 22, 2016, OWCP found that the May 2, 2016 incident occurred as alleged, but denied the claim because causal relationship had not been established. It noted that appellant provided medical evidence establishing that she had previously been diagnosed with cervical conditions, and that the record contained no medical opinion evidence indicating that the May 2, 2016 automobile accident was a direct cause or aggravation of a diagnosed condition.

On December 22, 2016 appellant, through counsel, requested reconsideration. He submitted reports from Dr. Scott C. Hitchcock, an osteopath who is Board-certified in neurology, dated December 16, 2010 to January 26, 2016, in which he reviewed appellant's cervical complaints. In a December 16, 2010 report, Dr. Hitchcock noted appellant's complaints of neck pain and cervicogenic headaches that began many years prior when she was in a severe motor vehicle accident with a dump truck. He noted his review of her cervical spine MRI scan that appeared normal except for some straightening of the normal lordotic curve. Dr. Hitchcock advised that appellant likely had myofascial pain.

By report dated May 9, 2016, Dr. Hitchcock noted that since a recent motor vehicle accident when appellant's vehicle was struck from behind, her neck pain had been much more severe. He reported that the post-accident MRI scan of her cervical spine showed herniated discs and degenerative changes from C3-5 and that he was going to refer her to neurosurgery for possible surgical options. Dr. Hitchcock advised that appellant was disabled from chronic neck pain and had not been able to work. He diagnosed myofascial pain syndrome, chronic pain syndrome, and spondylosis of cervical region without myelopathy or radiculopathy. In correspondence dated June 8, 2016, Dr. Hitchcock noted that since the May 2, 2016 motor vehicle accident, appellant's preexisting severe chronic neck pain had become much worse and that she was disabled from work. In reports dated June 17 and September 29, 2016, he reiterated his conclusions and further diagnosed cervicogenic headaches, chronic migraine headache, cervical dystonia, and chronic insomnia. An August 26, 2016 electroencephalogram (EEG) was interpreted as normal. In correspondence dated November 14, 2016, Dr. Hitchcock noted that following the May 2, 2016 motor vehicle accident, appellant was immediately dizzy which was consistent with concussion and then developed intense chronic post-traumatic migraine headaches which had been difficult to control. He related that prior to the accident, he felt most of appellant's dysfunction was from myofascial pain syndrome, but that since the accident, she had developed cervical dystonia.

[4] Copies of the March 3, 2016 MRI scan and May 2, 2016 CT scan are not found in the case record.

Dr. Hitchcock concluded that the May 2, 2016 motor vehicle accident exacerbated appellant's preexisting conditions.

In a report dated September 12, 2016, Dr. Kelley Smith, a Board-certified cardiologist, noted a history of appellant's chronic neck pain syndrome worsened by a motor vehicle accident in May, and reported that recently appellant had an episode of syncope when she rose from sitting, had a syncopal event and fell, striking her left upper face. He reported that she went to the emergency department a day later, had a negative CT scan of the head, and was diagnosed with concussion, and that Dr. Hitchcock had done an EEG which was negative. Dr. Smith noted that an electrocardiogram (ECG) on September 12, 2016 was abnormal. Following examination, he diagnosed abnormal ECG, chronic pain syndrome, cervical disc degeneration, insomnia, syncope and collapse. An echocardiogram on September 13, 2016 was normal. On September 29, 2016 Dr. Smith diagnosed syncope and collapse (primary), sick sinus syndrome, abnormal ECG, unspecified tachycardia, cervical disc degeneration, and chronic pain syndrome.

On November 10, 2016 Dr. Warren Foster, a Board-certified cardiologist, noted a history of the motor vehicle accident and syncopal episode. He performed physical examination, diagnosed syncope and collapse (no recurrence) and unspecified tachycardia. Dr. Foster opined that the diagnostic etiology included medications, pain, anxiety, and inappropriate sinus tachycardia.

Dr. Smith saw appellant on November 14, and December 6, 2016. He indicated that episodes of sudden onset regular tachycardia were triggered after a motor vehicle accident with neck injury and chronic pain syndrome and that she had some spontaneous diaphoretic episodes with no chest pain with exertion. Dr. Smith reiterated his diagnoses. By letter dated December 6, 2016, he diagnosed syncope and collapse, sick sinus syndrome, abnormal ECG, chronic pain syndrome, unspecified tachycardia, and dizziness and giddiness. Dr. Smith opined that since she had not reported cardiac symptomology prior to the May 2, 2016 motor vehicle accident, it played a role in triggering her symptoms and diagnoses.

In correspondence dated December 14, 2016, Dr. Hitchcock reiterated his findings and conclusions that the May 2, 2016 motor vehicle accident exacerbated appellant's preexisting conditions.

By decision dated March 14, 2017, OWCP denied modification of its prior decision. It found that the medical evidence submitted did not provide a complete and accurate factual history, and that some reports were not contemporaneous with the time of injury. OWCP noted that appellant had been in a previous motor vehicle accident, as reported by Dr. Hitchcock on December 10, 2010, and that a previous claim, adjudicated by OWCP under File No. xxxxxx931, had been denied. It noted that Dr. Hitchcock reported problems with myofascial pain syndrome and cervical dystonia on December 16, 2010, which contradicted his November 14 and December 14, 2016 reports. OWCP noted that there were gaps in the medical evidence provided and found the medical evidence presented was not of sufficient probative value because it lacked sufficient medical reasoning.

On January 12, 2018 appellant, through counsel, requested reconsideration. Counsel maintained that the medical evidence presented by Dr. Hitchcock and Dr. Smith was sufficient to establish that the May 2, 2016 motor vehicle accident caused an aggravation of preexisting

myofascial pain syndrome and migraine headaches, a return of cervical dystonia, and new conditions of tachycardia, abnormal ECG, syncope, and fibromyalgia.

Appellant submitted a June 7, 2017 report in which Dr. Smith advised that appellant's chronic pain syndrome was a major factor, as her cardiac symptoms were directly related to the effectiveness of her pain management.

In a July 31, 2017 report, Dr. Hitchcock opined that appellant was totally disabled from work. He indicated that after six months of treatment appellant's symptoms did not dissipate, that he felt that she was possibly suffering from fibromyalgia, and that he had referred her to Dr. James Thacker, an anesthesiologist, for pain management. Dr. Hitchcock noted that he later referred her to Dr. Vijayanarayana R. Jampala, a Board-certified rheumatologist, who found all results of autoimmune disorders negative and who diagnosed fibromyalgia, cervicalgia, myalgia, and headache. On October 31, 2017 Dr. Hitchcock reiterated his findings and conclusions, indicating that appellant was totally disabled from work. He requested that the conditions of fibromyalgia, spondylosis of the cervical spine, and cervical dystonia be accepted as triggered by the May 2, 2016 motor vehicle accident. In correspondence dated January 4, 2018, Dr. Hitchcock noted that appellant had first been in a motor vehicle accident at age 18, but had recovered and had thereafter competed in sports and completed employing establishment training. He indicated that on the emergency department report on May 2, 2016 a physician confirmed complaints of ringing in the ears, headache, dizziness, shoulder pain, and a visible seat belt mark across her body, compatible with a severe whiplash injury. Dr. Hitchcock provided diagnoses of cervical dystonia, myofascial pain syndrome, degenerative disc disease, chronic pain syndrome, migraine headaches, chronic insomnia, bulging and herniated discs with bone spurs at C3 to C6, and osteoarthritis of the cervical spine.

By decision dated May 2, 2018, OWCP denied modification of its prior decisions. It found the medical evidence of record insufficient to establish her claim, noting many reports were not contemporaneous with the date of injury.

LEGAL PRECEDENT

An employee seeking benefits under FECA[5] has the burden of proof to establish the essential elements of his or her claim including the fact that the individual is an employee of the United States within the meaning of FECA, that the claim was timely filed within the applicable time limitation of FECA, that an injury was sustained in the performance of duty as alleged, and that any disability or specific condition for which compensation in claimed is causally related to the employment injury. These are the essential elements of each and every compensation claim regardless of whether the claim is predicated upon a traumatic injury or an occupational disease.[6]

In order to determine whether an employee actually sustained an injury in the performance of duty, OWCP begins with an analysis of whether fact of injury has been established. Generally, fact of injury consists of two components which must be considered in conjunction with one another. The first component to be established is that the employee actually experienced the employment incident which is alleged to have occurred. The second component is whether the

[5] *Supra* note 2.

[6] *D.J.*, Docket No. 18-0620 (issued October 10, 2018).

employment incident caused a personal injury and generally can be established only by medical evidence.[7]

To establish causal relationship between the condition, as well as any attendant disability claimed and the employment event or incident, the employee must submit rationalized medical opinion evidence supporting such causal relationship.[8] The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty, and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant. This medical opinion must include an accurate history of the employee's employment injury and must explain how the condition is related to the injury. The weight of medical evidence is determined by its reliability, its probative value, its convincing quality, the care of analysis manifested, and the medical rationale expressed in support of the physician's opinion.[9]

ANALYSIS

The Board finds that appellant has not met her burden of proof to establish that her diagnosed medical conditions were causally related to the accepted May 2, 2016 employment incident.

Initially, the records from appellant's emergency department visit on May 2, 2016 listed diagnoses, but offered no history of injury or opinion regarding causal relationship. The Board has held that medical evidence that does not offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[10]

The medical report most contemporaneous with the May 2, 2016 motor vehicle accident was the May 9, 2016 report from Dr. Aaron who noted that appellant had recently been in an automobile accident and provided examination findings. Dr. Aaron did not render a diagnosis that day. In a prior report, predating May 9, 2016, he had diagnosed degenerative changes of the cervical spine from C3 to C6. A rationalized opinion is especially important as the evidence supports that appellant had a preexisting cervical condition.[11] The Board has also held that medical evidence that does not provide a firm diagnosis and offer an opinion regarding the cause of an employee's condition is of no probative value on the issue of causal relationship.[12] Dr. Aaron's opinion is, therefore, insufficient to establish appellant's claim. Likewise, as Dr. Johnson and Dr. Foster did not render an opinion on causal relationship, their opinions are also of no probative value and, thus, are insufficient to establish appellant's claim.[13]

[7] *K.L.*, Docket No. 18-1029 (issued January 9, 2019).

[8] *M.C.*, Docket No. 18-0951 (issued January 7, 2019).

[9] *K.L.*, *supra* note 7.

[10] *See J.P.*, Docket No. 18-1165 (issued January 15, 2019).

[11] *See C.C.*, Docket No. 17-1981 (issued January 23, 2019).

[12] *See C.C.*, Docket No. 18-1099 (issued December 21, 2018).

[13] *Supra* note 10.

Dr. Hitchcock submitted reports dated December 16, 2010 to January 4, 2018. He diagnosed numerous conditions and suggested that the conditions of fibromyalgia, spondylosis of the cervical spine, and cervical dystonia were triggered by the May 2, 2016 motor vehicle accident and had exacerbated preexisting conditions. The Board finds that his opinion was speculative in nature as he did not sufficiently explain how the accepted incident caused the disabling conditions.[14] Medical reports without adequate rationale on causal relationship are of diminished probative value and do not meet an employee's burden of proof.[15] The opinion of a physician supporting causal relationship must rest on a complete factual and medical background supported by affirmative evidence, address the specific factual and medical evidence of record, and provide medical rationale explaining the relationship between the diagnosed condition and the establish incident.[16] Without explaining how, physiologically, the movements involved in the employment incident caused or contributed to a diagnosed condition, Dr. Hitchcock's opinion is of limited probative value and insufficient to establish causal relationship.[17]

Dr. Smith began treating appellant in September 2016, seven months after the May 2, 2016 employment injury. He reported that appellant had recently had a syncopal episode and gone to the emergency room. The record, however, does not contain an emergency department report of a syncopal episode. Dr. Smith noted abnormal ECG findings and diagnosed chronic pain syndrome, cervical disc degeneration, insomnia, syncope, and collapse. While he opined that, since appellant had not reported any cardiac symptomology prior to the May 2, 2016 motor vehicle accident, the employment incident played a role in triggering her symptoms and diagnoses. An opinion that a condition is causally related to an employment injury because the employee was asymptomatic before the injury, but symptomatic after it is insufficient, without supporting rationale, to establish causal relationship.[18] As Dr. Smith provided no other rationale in support of his opinion, the Board finds that it is insufficient to meet appellant's burden of proof.

On appeal counsel maintains that the medical evidence of record is sufficient to establish causal relationship. Contrary to this assertion, causation in the instant case has not been established because none of the medical evidence of record explained with sufficient rationale how appellant's diagnosed conditions were caused or aggravated by the May 2, 2016 incident.[19]

As the record lacks rationalized medical evidence establishing causal relationship between the May 2, 2016 employment incident and appellant's diagnosed conditions, she has not met her burden of proof.[20]

[14] *See G.M.*, Docket No. 18-0989 (issued January 3, 2019).

[15] *S.H.*, Docket No. 17-1660 (issued March 27, 2018).

[16] *See M.C.*, *supra* note 8.

[17] *Id*.

[18] *C.C.*, *supra* note 11; *John F. Glynn*, 53 ECAB 562 (2002).

[19] *M.C.*, *supra* note 8.

[20] *K.L.*, *supra* note 7.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that appellant has not met her burden of proof to establish that her diagnosed medical conditions were causally related to the accepted May 2, 2016 employment incident.

ORDER

IT IS HEREBY ORDERED THAT the May 2, 2018 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 20, 2019
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Valerie D. Evans-Harrell, Alternate Judge
Employees' Compensation Appeals Board